

CORRECTION SHEET.

In view of the change in location of the H.Q. U.S.A. S.O.S. the following sentence, on page one:-

"The correct address of the Medical Supply Depot this area is." is changed to read:-

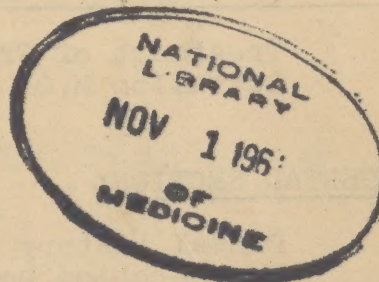
"The correct address of the Medical Supply Depot in the Melbourne area is:-

W 2
A 2
9 F 55 M - 60
300.5

THE MONTHLY BULLETIN.

NUMBER 4.

SEPTEMBER, 1942.



OFFICE OF THE SURGEON,
UNITED STATES ARMY SERVICES OF SUPPLY, SOUTH WEST PACIFIC AREA.

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ADMINISTRATION SECTION.

CONTRIBUTIONS TO THE BULLETIN.

The Commanding Officers of all hospitals in the S.W.P.A. are earnestly requested to urge the chief of each service under his command to stimulate the submission of short articles or clinical notes by the members of his staff for consideration by the Chief Surgeon as material for publication in future issues of the Bulletin. It will be obvious that the experience of any individual may be limited as far as warfare is concerned, but that should not act as a deterrent when even a limited experience may indicate the presence of an important unexpected problem, or may serve as a guide to improve our methods of dealing with any of the common conditions.

POSTAL ADDRESS.

In view of the fact that there has been a change in the name of the organisation, all communications to this office will in future be addressed to:

The Chief Surgeon,
Hq., U.S.A.S.O.S., S.W.P.A.,
A.P.O. No. 501

The correct address of the Medical Supply Depot this area is:

Medical Supply Depot,
U.S.A.S.O.S., S.W.P.A.,
A.P.O. No. 924.

ACTIVATION OF 3rd MEDICAL LABORATORY.

The 3rd Medical Laboratory, U.S.Army, is now prepared to furnish laboratory facilities for all medical installations in Australia.

The stationary section of the 3rd Medical Laboratory is now located at the:

School of Veterinary Science,
Queensland University
Fairfield Road,
YEERONGPILLY. Q'land.

FOREWORD

The Monthly Bulletin - Office of the Chief Surgeon, USA SOS., is published for the purposes of disseminating information of general interest and of Administrative value to the Medical Department personnel of the United States Army Forces in Australia.

While the information contained herein will be compiled from information available in the Office of the Chief Surgeon, all Medical Department Officers and agencies are invited to submit items of general interest. Such material will be published as soon as practicable.

It is not intended that the material herein contained shall have the force of directives, but should be used as a guide by those concerned.

It is with the hope of assisting Medical Department personnel with their problems that this Bulletin has been initiated.

The address of this section should appear on all labels as:-

3rd Medical Laboratory,
U.S. Army,
A.P.O. 923

This laboratory is now in operation and is ready to receive all types of pathological work, such as bacteriology, serology and pathology. Specimens may be sent direct to the laboratory by ordinary mail, by air mail, or may be left at the headquarters dispensary, Surgeon's Office, Base Section No. 3.

An instruction sheet on the preparation and shipment of specimens is being prepared at the present time and will be forwarded at a later date. In the meantime, it is suggested that great care be used in packing material; for example, do not send blood, spinal fluid specimens or water samples in tubes which have only cotton plugs for stoppers.

The main purpose of this laboratory and of the mobile laboratories, later to be established, will be to give laboratory service to the smaller detachments and units in Australia. The general hospital laboratories will continue to do most of their work as at the present time. Smaller hospitals should do as much of their own work as possible. The 3rd Medical Laboratory is established to help all hospital units and all medical establishments whenever necessary.

YELLOW FEVER VACCINE.

Information has been received from Washington that Item 16129 Yellow Fever Vaccine, will no longer be furnished for automatic maintenance and that officers and men embarking from the United States will be vaccinated only if they are proceeding to or through areas in which yellow fever is endemic.

The Surgeon General defines the endemic yellow fever areas as follows:-

In the Western Hemisphere, the mainland of South America lying between latitudes 13 degrees North and 30 degrees South, including the islands immediately adjacent.

In the Eastern Hemisphere, the portion of Africa lying between latitudes 16 degrees North and 12 degrees South, including the islands immediately adjacent.

REQUISITIONS FOR NON-STANDARD ITEMS.

Requisitions for Non-Standard Items of supply and equipment will be held to an absolute minimum.

Requisitions for Non-Standard Items will be submitted in the usual manner, through the usual channels, and will be accompanied by a letter of transmittal stating, in detail, the necessity for each item and, if the Medical Supply Catalogue contains one of similar type or character, full information as to why the Standard Item will not suffice and in what manner the item requested differs from and is an improvement over the Standard.

Base Section Surgeons will carefully scrutinize these requisitions to ascertain whether the requisition is justified. Each requisition will be modified, when necessary, as to quantity and type of item to be issued, keeping in view the prevention of issues of items not required by the Unit. Any corrections or modifications made will be noted on all copies of the requisition which will then be forwarded to the designated issuing depot.

EXTRACTS FROM W.D. CIRCULARS.

Efficiency Reports:- The suspension of periodic reports on officers below field grade may do grave injustice to outstanding individuals and to the Government unless meritorious service is made a matter of permanent record in the War Department. All commanders will take full advantage of the authority granted in paragraph 2c, section IV, Circular No.79, War Department, March 17 1942, by submitting special reports, full or abbreviated, on outstanding junior officers whenever this action would be to the best interest of the service.

Rations:- Paragraph 1, section V, Circular No.134, War Department May 5, 1942, is rescinded and the following substituted therefor:

1. Effective June 1, 1942, the field rations as described in paragraph 4d, AR 30-2210, is prescribed for use for troops outside the continental limits of the United States and Alaska, except for fixed station and general hospitals. Such hospitals may be placed on a garrison ration or a field ration status with increased allowances as provided in paragraph 11a, AR 40-590. These increased allowances will be effected by payment of the cash value thereof to the custodian of the hospital fund for the purpose of making local procurement of special items of diet required for hospital patients.

Battle casualty reports:- Paragraph 1c (3), Circular No.21, War Department, Jan. 24th 1942, is rescinded and the following substituted therefor:

1c (3) (a) Reports will contain the following data:

1. Name
2. Grade
3. Serial number
4. Date of death
5. Whether line of duty
6. Whether in flying status.
7. Amount of one full month's pay.

(b) It is of the utmost importance that names and Army serial numbers be reported accurately, and in case of death that the exact date be given.

Reports of death of military personnel occurring outside continental United States - Changes in AR 600-550.- Pending the revision of AR 600-550, March 6, 1936, paragraph 5z(1) of those regulations is rescinded and the following substituted therefor:

5a(1) W.D., A.G.O. Form No.52, in duplicate, accompanied with the necessary reports and records will be forwarded to the commanding general of the foreign service command, who immediately upon receipt of such report will notify the Adjutant General by cable or radio as follows:

- a. Full name of decedent.
- b. Army serial number
- c. Grade, company, regiment, separate battalion, or similar separate unit or arm or service, if unassigned.
- d. Date and place of death, nature of injury or disease, and direct cause of death.
- e. Whether or not in flying status.
- f. Whether death was or was not in line of duty and was or was not the result of his own misconduct; if undetermined, a statement to that effect.
- g. Statement to the effect that the question of line of duty and misconduct is not to be determined by a board of officers.
- h. Amount of one full month's pay based upon grade at time of death, including flying pay as distinguished from allowances.
- i. Technician grade, if any.
- j. Qualification for which soldier received additional pay, if any.
- k. Statement to the effect that the information contained in the cablegram or radiogram is in conformity with the data embodied on W.D., A.G.O. Form No.52.
- l. Conjugal condition, including given name and address of widow or dependent children, if any, and the name, address, and relationship of emergency addressee. If no widow or dependent children, the name, relationship, and address, if known, of other dependent relative

designated as beneficiary.

- m. Arm, service or bureau by which employed (if a permanent civilian employee).

(A.G. 210.86 (6-6-42)).

Section 111, W.D. Circular 235 - "111. Daily Sick report -- Changes in AR 345-415. - Pending the revision of AR 345-415, November 23, 1933, the words "organization or detachment commander", wherever they appear in paragraph 3g and h of those regulations, are changed to read "Personnel Officer". (A.G. 201.3 (7-15-42))".

Section V, W.D. Circular 235 - "V.- Record of prescriptions for spectacles. - The last sentence of Section 1, Circular No. 196 War Department, 1942, is amended to read as follows:-

In the case of officers these data will be entered on W.D. M.D. Form No. 81 (Immunization Register), and in the case of enlisted personnel on page 15, W.D., A.G.O. Form No. 24 (Service Record).

(A.G. 413.75 (6-6-42))".

MEDICAL, DENTAL AND VETERINARY ARTICLES FOR PUBLICATION.

1. All articles written for publication by medical, dental and veterinary officers of the United States Army, assigned to USASOS, SWPA, will be submitted through medical channels to the Chief Surgeon, USASOS, SWPA, for approval before being submitted for publication in Australian professional journals or before being mailed to the United States for publication in professional journals there.
-

MEDICAL CHANNELS.

All medical department organizations, except general hospitals, will transact all official business with the Base Section Surgeon concerned. Direct communication with the Chief Surgeon's office will not be resorted to unless with the approval of the Base Section Surgeon.

MEDICAL TREATMENT.

It is desired that medical and hospital treatment be given to all United States citizens who are veterans of any War, provided they present credentials to substantiate their claims as veterans.

MEDICAL AND DENTAL SERVICES IN AUSTRALIA.

1. The United States Army Medical Department is now prepared to furnish all military personnel with medical and dental care, except personnel in some isolated areas in cases of extreme emergency. Hereafter, every effort will be made to obtain medical and dental treatment from United States Army installations before incurring any obligations from civilian sources.

2. Except in the case of an extreme emergency or in an isolated area where treatment by military personnel is not obtainable, the payment of bills for medical and dental treatment incurred by individuals dealing directly with civilian physicians and dentists will be disapproved and payment for such obligations will be the responsibility of the individual concerned. GSXM 701.2 (21-8-42) Surg.

MEDICAL INFORMATION NECESSARY FOR PURPLE HEART AWARD.

1. The following extract from AR 600-45, August 8, 1932 paragraph 11B. in regard to the awarding of the Purple Heart is quoted hereunder for the information of all concerned:

11B. A wound, which necessitates treatment by a medical officer and which is received in action with an enemy of the United States, or as a result of an act of such enemy, may, in the judgment of the commander authorized to make the award, be construed as resulting from a singularly meritorious act of essential service. See Paragraph 3c, AR 40-1055.

2. In connection therewith it is desired to place particular emphasis on the fact that the Emergency Medical Tag, Medical Department form 52B is ordinarily the only evidence available on which the appropriate commander may base a recommendation for the award of the Purple Heart. It is therefore necessary that every individual wounded in action be seen by a medical officer, and that the name and grade of the individual, serial number, diagnosis, a specific statement that it was incurred in action, hour and date of incurrence of

injury, together with the signature of the attending medical officer be shown on the Tag.

RATIONS FOR PATIENTS IN HOSPITAL.

"1. Establishing value for commutation of hospital rations. -
1. The following extracts, AR 40-590, are quoted for the information and guidance of all concerned:

'11. Commutation of rations - a. General.

(1) The ration of any of the following classes, while a patient in a hospital, dispensary, hospital ship, Army transport, hospital train, or convalescent camp, pertaining to the Army, will be commuted at the rate indicated in (2) below:

(a) Enlisted men in the active service of the United States (including enlisted men of the Philippine Scouts).

(b) Enlisted men of the National Guard, National Guard Reserve, or Enlisted Reserve Corps admitted from training camps or service schools.

(c) Discharged enlisted men undergoing treatment under the provisions of paragraph 6 or 7 g.

(d) Applicants for enlistment.

(e) Civilian employees of the Army who are entitled to subsistence at public expense.

(f) Prisoners.

(g) Destitute persons admitted to hospital under the provisions of paragraph 6b(19).

(2) The ration of patients enumerated in (1) above will be commuted as follows:

(a) At establishments maintained for the treatment of tuberculous patients, and for tuberculous patients at other establishments, at the actual cost of the ration plus 90 per cent.

(b) In all other cases, at the actual cost of the ration plus 50 per cent.

(3) The term ration, as used in (1) above refers to the "garrison ration" unless otherwise directed by proper authority in time of war.'

2. Pursuant to provisions of WD Circular 216, section 111, the ration for use in installations covered by AR 40-590, paragraph 11, is hereby designated for this theater of operations as the field ration with an "actual cost" value of three shillings (3/-) per ration. GSXM 430.2 (24-8-42) QM."

2. Vouchers covering the commutation of rations and the payment thereof will be made as prescribed in AR 40-590, paragraph 11d(1).

PROFESSIONAL SECTION

TREATMENT OF FRACTURES.

As most fractures occur at a considerable distance from any hospital it is extremely important that all medical personnel understand the fundamental principles in their treatment.

The first in importance is to protect the fracture as soon as possible; even if there is a question of the diagnosis, an emergency spint should be applied before the patient is moved, "Splint them where they lie" is the primary dictum. A rapid estimation of the patient's general condition should be made to determine dangerous hemorrhage or shock. Hemorrhage should be treated immediately, and shock should be treated by morphine, heat and hot drinks, and blood plasma if available.

Emergency Treatment of the Fracture.

Ambulance and mobile units are supplied with army Thomas leg and arm plints and these should always be used if available. However many splints may have to be improvised out of available material from boards, rifles, crating, etc., and padded temporarily with folded clothing or blankets if cotton is not available.

The Thomas leg splint should be used for all fractures of the lower extremity except those of the foot and ankle. Slip the half ring of the Thomas beneath the thigh at the gluteal crease over the trousers, without removing the shoe. Throw a bandage hitch about the ankle and tie to the end of the splint and tighten with tongue blade or stick windlass. Secure the leg to the splint with bandages or slings. If patient is to be transported by ambulance the Thomas Splint should be fixed to the stretcher bars on each side by metal bars if available; if not they should be lashed securely with cord or bandage to the stretcher bars with the foot of the Thomas Splint elevated on blocks or folded towels.

For the lower extremity, in a fracture below the knee, when a Thomas Splint is not available, any splint should extend from the hip to below the ankle joint. In other words, always splint the joint on either side of a fracture. If the femur is involved an external splint should be applied from the axilla down past the foot on the outside, and from the groin to the foot on the inside. Then, both legs can be tied together. In applying any kind of a splint to the lower extremity one person should firmly grasp the foot and gently, and steadily, apply traction until the extremity looks straight.

In fractures of the shoulder or upper arm the simplest method is to tie the arm to the chest, incorporating a sling around the forearm and elbow, with the axilla padded with a folded shirt. In forearm fractures a board splint should be applied from the elbow to the base of the fingers. After this emergency splinting has been applied the patient can be moved.

In any suspected fracture of the spine the patient should always be turned over on the abdomen, face down, for transportation either on a litter or a blanket. He should never be carried in a flexed position.

GENERAL CONSIDERATION.

Diagnosis.

The subsequent treatment of any fracture depends upon an accurate diagnosis. The emergency splint should not be removed before the taking of X-rays. As a rule, at least three sets of X-rays should be taken on each case; one for diagnosis, one after reduction and one before removal of splints or plaster. Many shaft fractures can be diagnosed by swelling, deformity, crepitus and point bony tenderness, without X-ray.

Reduction.

All fractures should be treated as emergency cases and reduction obtained immediately. If there is delay in the reduction of fractures the difficulties increase with each 24 hours. More force is needed, the tissues have become swollen and have lost their elasticity; eventually muscle edema and fibrosis make reduction extremely difficult and, at times, impossible.

In reducing the fracture one must strive for perfect anatomical reduction. Good functional reduction of a fracture is however much better than too many attempts at reduction wherever full facilities are not available. A slight amount of overriding of two fragments may give perfect functional results, if the fragments are in perfect alignment. The two deformities that are serious are angulation of the fragments in any plane or rotation of the fragments, even if they are end on.

Many fractures which are properly treated immediately after injury are in almost perfect position when they are first X-rayed and need no reduction except gentle molding while being put into plaster or in a splint. If, however, several hours have elapsed and emergency treatment has been neglected a major reduction will have to be made.

Anaesthesia.

Fractures involving joints or the large bones should be reduced under anaesthesia. Most fractures can be perfectly reduced under local anaesthesia with 1 or 2% novocaine injected directly into the hematoma of the fracture. This relieves muscle spasm and pain within a few minutes and ordinary traction and manipulation can be carried out satisfactorily. A general anaesthetic must be used in all cases where heavy, strong traction is applied over the skin or in extremely muscular individuals who will not co-operate. As a rule, general anaesthesia is advisable in all compound fractures.

Reduction Methods.

Most reductions are made by the use of traction and counter-traction and if the reduction is difficult counter-traction is very important and should always be used. A folded sheet or blanket can be used for counter-traction. For the lower extremity the sheet can be passed through the crotch and tied to a post or the head of a bed. For tibial traction use the popliteal space for counter-traction. For the upper extremity the sheet or blanket can be passed under the axilla and fastened to a solid object. In difficult forearm fractures involving both bones counter-traction should be applied on the lower end of the humerus in the cubital fossa.

A favorable position of the extremity greatly facilitates reduction, the general rule being to have all joints in a mid position during the manipulation. For example, it takes much more force to reduce a tibial fracture if the hip and knees are extended and the foot dorsiflexed, because the strong calf muscles are taut in this position. Difficult tibial fractures should be reduced with the knee flexed and the foot plantar flexed. In difficult fractures traction can be applied by a hitch over the foot or wrist and passed around the operator's waist. This leaves both hands free and available for palpation and manipulation of the fragments. In strongly impacted fractures as is frequently found in the Colles fracture, all impactions must be broken up by manipulation before reduction can be achieved.

Fractures that are oblique, spiral or severely comminuted may need continuous traction reduction, Buck's adhesive traction, or skeletal traction should be used, if available, and the patient is in a stationary hospital.

Immobilization.

All fractures should be immobilized until bony healing has

taken place. The time of immobilization varies within wide limits. However, upper extremity fractures and fractures through non weight bearing bones take less time than fractures in the lower extremity, or in weight bearing bones. Two to three weeks time for protection of a toe, if a shoe can be worn is enough while the minimum time for a fractured tibia is probably three months and for a femur, six months. Do not remove splints until there is definite evidence of healing.

Where at all possible plaster paris should be used for the immobilization of fractures, padded or unpadded, according to the experience of the surgeon in the use of plaster. Well molded plaster strips are safer, if there is danger of much post-reduction swelling, than solid circular casts. The plaster cast should be comfortable and the circulation in the extremities should be always checked within the first 24 hours after reduction. Many fractures, such as a Colles fracture, can be immobilized on wooden splints with complete satisfaction; while others, such as the humerus, can be treated with metal splints. These, of course, should be firmly applied, carefully padded and frequently checked, because they have a tendency to shift and loosen. Unless the patient with a circular plaster is to be in the hospital where he may be observed constantly, the cast should be split or bivalved.

COMPOUND FRACTURES.

There are two types of compound fractures - the direct and the indirect. The direct compound fracture, which has been caused by a direct tearing of the skin over the fracture (as in battle wounds) is much more serious than indirect compounding of a fracture, which may be due to a puncture wound by a sharp bone fragment from within. As a rule, the latter are not contaminated with dirt or foreign bodies and need little debridement. The direct compound fractures are usually contaminated with foreign bodies, such as clothing, gravel, bullets, etc., and they are all potentially infected. The treatment of compound fractures requires judgment and speed. The time element is extremely important and they should be treated as emergencies. The longer a wound has been untreated the higher the bacterial contamination and the more dangerous it is to close the wound. As a general rule, if more than six or eight hours has elapsed between the time of the injury and debridement of the wound, it should be packed open and immobilized.

Debridement of the Wound.

This procedure should be carried on under anaesthesia. First, the extremity should be carefully cleansed with soap and water, while a sterile dressing is held over the wound. Next, the wound itself should be thoroughly and carefully explored, and washed out, preferably with a steady stream of saline in large amounts. 1,000 to 2,000 c.c.'s of saline is not too much to use for cleansing and irrigation. The depths

of the wound are cleansed first and all foreign material carefully-removed. All devitalized muscle and fascia should be trimmed away. Large pieces of bone should be left in place. In order to cleanse deeper pockets it may be necessary to enlarge the skin and fascial wounds to give proper exposure. Very little suture material should be left in the wound. If the fracture is recent, the wound should be closed loosely without tension, after edges of ragged skin have been excised. In order to close the skin over a superficial bone, it is occasionally advisable to make a relaxing incision on each side of the main wound; so that the skin can be closed without tension. The relaxing skin incision can be left open. Once the wound is closed the extremity should be immobilized, as in a simple fracture. Many wounds heal faster in a plaster cast than when exposed on a splint.

All compound fractures should be given gas bacillus anti-serum and tetanus anti-toxin, if not immunized with tetanus toxoid, when first seen, if available. Many of these cases should be treated for shock, with the intravenous administration of blood, plasma or saline. Sulphathiazol powder should be placed in the wound whether it is left open or closed. Patients who have received active tetanus immunization may be adequately protected by a "booster" dose of tetanus toxoid.

Open Reduction and Plating.

Certain fractures should be treated by internal fixation and others will require the use of the Roger-Anderson or similar equipment. As a general rule plating should be avoided except by those expert in this method of treatment and only in the larger fixed hospitals, where the patient may be kept under continuous observation up to the time of healing. This method of treatment requires more than ordinary judgment, skill, and experience. When well done, in properly selected cases, the results are excellent. Imperfection in technique and selection of cases may cause serious consequences, avoidable by the use of the simpler methods of treatment.

THE BATTALION MEDICAL OFFICER.

(Reprinted from The Army Medical Bulletin No.61, April, 1942.)

The battalion medical officer probably enjoys the most individualistic responsibility of any officer in the service. His colleagues attached to sorting stations, ambulance companies and evacuation hospitals have the advantage of contact and conference, something which may be denied him during periods of military action.

It is obligatory that the battalion officer be young, vigorous, and in perfect health in order to withstand the rigors of accompanying his unit during active campaigning. He must master subjects foreign to his civilian training; to mention a few, these include troop hygiene and sanitation, medical corps training and drill, map reading, orientation, and something of tactics and the art of concealment. Emphasizing only one, the training of his enlisted personnel is a genuine test; and there are many other fields to explore, such as gas-proofing, the selection of sheltered havens where battle casualties may be protected, and finally the problem of feeding the wounded.

He may consider these duties professional inactivity, but there will follow periods when all of his medical acumen will be required and the military demands will be even less exacting than the professional responsibilities. During severe and sustained action he must retain coolness, calmness, and a nicety of surgical judgment under the most adverse conditions. This latter is an indefinable but essential attribute compiled of just the right mixture of a stable nervous system, past surgical experience, common sense, and an ever ready diagnostic ability. It may seem a needless sacrifice, but wars are won only by sending the best men to the front.

The battalion medical officer's responsibilities make demands upon his previous training but these differ widely from his past experience. He most certainly has never before been suddenly confronted with a half gross or more of injuries running the gamut of head, chest, abdomen, and extremities, nor has he ever before worked to the limit of his physical and mental capacities where all about him are chaos and confusion. True, there is little in the routine but essential military training that fits him to meet this sudden and overwhelming activity, but experience can be simulated by military manoeuvres and through special training from his regimental and division surgeons.

In fact, no greater duty rests upon the division surgeon than to see that his first line officers are selected from men who have had some civilian traumatic experience. Even so, they should be taught the routine and correct use of tourniquets and traction splints, the differentiation between traumatic and cerebral shock and a profound medical appreciation of the effects of dehydration, exposure, and hemorrhage upon wounded men. In this training the time element should be stressed as all important. The rapid collection of wounded and their intelligent dispatch to the rear definitely determines the mortality rate of almost all except the initially fatal injuries. Many of these problems are those which never confront the physician in civilian practice, since the ever ready and fast ambulance delivers the casualty to the hospital receiving room usually within a matter of minutes.

There exists the notion among young medical graduates that an appointment to operative surgical teams and to base hospitals offers opportunities to gain vast experience in chosen specialties, whereas being assigned as battalion medical officer engenders atrophy of previous knowledge and experience. This is absurdly wrong.

With a few individual exceptions war surgery in World War I taught the physician very little. As a member of an operating team he found the technique of debridement destructive rather than constructive and the type of injury differed greatly from that seen in civilian life. There was, moreover, no opportunity to observe the end results of operations done. In base hospitals the surgery was and will be done by a few men and the junior officer will act as the equivalent of a house officer in a well organized civilian institution. Finally, between the surgical units operating near the field of battle and the combat battalion, there is little or nothing in the way of practical civilian medical experience to be acquired.

The battalion officer, on the contrary, after a period of military training, may some day expect to find himself confronted with a number of injuries which would disorganize the largest civilian hospital in the United States. He may logically anticipate that in a relatively minor engagement ten percent of his men will be casualties and twenty-five percent of these will probably be fatally wounded. The percentage who live or die is positively influenced by his activity and professional skill. It seems unnecessary and almost stupid to call attention to the fact that obviously moribund patients should not be evacuated from the battalion aid station, yet this very information had to be repeated again and again to the vast majority of battalion surgeons during their early weeks of real action in the last war.

As physicians, all of us have been trained not to usurp the powers of Providence but to attempt to save every life even against impossible odds and to keep trying until life is fully and completely lost. This training cannot entirely function or endure upon the battlefields. Even to the unexperienced medical officer it must be obvious that he will be confronted simultaneously with hopelessly wounded, borderline cases, and with cases where reasonably prompt treatment and evacuation will result in recovery. He must learn under the trying conditions of active combat to recognize the doomed patients and to exercise that same calm impartiality shown by the judiciary when they pass sentence. He must refuse to clutter his limited evacuation facilities with the hopelessly wounded. It is platitudinous to state that, no matter how good the surgical equipment and personnel may be in the rear, they cannot save mortally wounded and dead men. The borderline cases present the real test of ability and many may be saved by proper de-shocking, either prompt mobilization or immobilization awaiting reaction, all depending upon the wound and the response to initial judgment and treatment.

In a lifetime of traumatic surgery the physician could scarcely be called upon to make decisions demanded daily of the battalion surgeon during such offensives as the Meuse-Argonne. Questions as whether to give more morphine or to withhold it, to continue de-shocking by external heat and posture or attempt to rush the patient to hospital, to loosen the tourniquet at the risk of death or to leave it tight and sacrifice a limb, to attempt to separate cerebral shock from traumatic shock, and to estimate the degree which cold, fright, dehydration, and exposure aggravated wounds were presented almost by the minute.

These are not flights of fancy but the cold reality which confronts the battalion surgeon hidden in a poorly lighted dug-out or in a shell hole under fire in the dead of night without adequate help, with some of his own stretcher bearers wounded and with the field around him still covered with badly wounded but unrecovered men. It should take but little imagination for the young officer to picture for himself the difference between this scene and the one in the hospital in which he trained, where an occasional casualty was brought in, where he had adequate professional assistance, superb nursing care, electric lights and blood transfusion available within ten or fifteen minutes after injury. The officer who feels that his professional talent will be wasted as a battalion surgeon simply hasn't been there.

It should be re-emphasized that he must exercise not only coolness and good sense but shrewd diagnostic acumen under the most adverse conditions without the benefit of counsel and often after twenty-four hours of constant duty.

The morale of any battalion is very positively influenced by the ability and the elan of its medical personnel. Combat troops, however courageous, react splendidly to the knowledge that if wounded and helpless on the field they will somehow be recovered by the medical corps and will receive prompt, adequate and competent care. The splendid records of many units can be partially credited to the courage and resourcefulness of their supporting medical detachments. There is no place in either civilian or military professional activity where gratitude and devotion are so generously given as to a real doctor in action with combat troops.

After recovery and segregation in the battalion aid station or the collecting station the most common question asked the medical officer by the wounded is "How seriously am I hit?" or "Am I going to get well?" and the reaction on the part of the patient to a cheerful and reassuring response is one of the most amazing phenomena of war wounds. It is second only to the dramatic reaction made by wounded men when placed in de-shocking cabinets and external heat applied.

The statistics as regards the mortality reduction when the application of traction splints on the field in 1915 was made a military order are too well known to need repeating here but the

imperative necessity of the application of traction before transportation cannot be overemphasized.

There is no possibility in this short space to discuss the intriguing differentiation in the treatments of exposure, hemorrhage, acidosis and shock. Books have been written about the signs, symptoms, and treatment of each one individually. The battle casualty presents a combination of all of these and the battalion surgeon will be amazed at the reactions of apparently desperately injured soldiers to reassurance, traction splinting, morphine, external heat, and hot fluids externally.

The treatment of infections and the chemotherapy of wounds by the use of sulfonamides likewise present a special problem in instruction.

Once in action the days of drill, sanitary inspections and foot work are forgotten and the battalion officer becomes again the professional man for which his long training has fitted him and which he has hoped to make his life work. Among medical veterans the expression is common that if they go again they want to serve with the troops, and it is not only the excitement but the actual professional responsibility which intrigues them.

Possibly good battalion surgeons are born, but certainly many can be made and the whole medical organization behind them is dependent upon their ability, while ahead of them the Army actually places its trust and its lives in their hands.

(Harold R. Conn, M.D.
Akron, Ohio.)

DENTAL HISTORY.

1. In accordance with paragraph 3, AR 40-1005, the senior dental surgeon in every unit is required to keep a daily diary as a part of the medical history of that unit.

2. It is desirable to keep the diary in detail and include the following data:- Description of working conditions, movements changes in personnel, outbreaks of dental diseases, pictures of dental equipment and dispensaries and any other item that would aid in compiling a history of the medical and dental services in Australia.

3. A summary of each dental surgeon's diary will be forwarded to this office every three months. The first summary should cover the period from September 1st, 1942, to November 30th, 1942 and should be forwarded with the Report of Dental

Service (Form 57 MD) for the month of November, 1942. Any interesting data available of activities prior to September 1st, 1942, should be included in the first summary forwarded.

BASE SECTION DENTAL LABORATORY.

1. Base Section dental laboratories have been established at Headquarters of Base Sections 1, 2, 3, 7 and at the 4th General Hospital for Base Section 4. These laboratories furnish dental laboratory service for military commands located within the designated territorial limits. The activities include laboratory procedures connected with the construction of dental replacements for personnel authorized to receive them. These dental laboratories are accountable for the expenditure of special dental materials used in constructing appliances for outlying officers.

2. The dental surgeon who takes the impression and inserts the appliance will take credit for the denture, bridge, repair, etc. on Form 57 MD. Form 124 MD, in duplicate, should accompany each case sent to the base section laboratory. One copy should be retained by the laboratory and the other copy returned with the finished case. A supply of these forms is available, in pads of 50, at the medical supply depots.

3. Dental officers should complete all extractions and filling operations on patients before taking impressions for prosthetic appliances. The prerequisites of a good prosthetic appliance are:-

- a. The proper preparation of the patient's mouth.
- b. Accurate impressions.
- c. Well defined models.
- d. True bite registrations.

Failure to construct proper fitting prosthetic appliances is due, in most cases, to inaccuracies in one or more of these steps. The laboratory will return work that is questionable, requesting a re-check, as time, labor and material may be wasted otherwise. Every effort will be made to construct appliances according to the design and with the materials requested, but the final decision rests with the Officer in Charge of the laboratory.

DENTAL CORPS INSIGNIA.

Dental Corps insignia are now being manufactured in Australia and are available at all U.S. Army Post Exchanges.

DELETIONS IN SUPPLY TABLE FOR CHEST 60 MD.

The following items have been deleted from the supply table for Chest 60 MD:-

50380	Bur, No. 8, A. Hp.	50770	Bur, No.200, St. Hp.
50530	Bur, No.558, A. Hp.	50780	Bur, No.202, St. Hp.
50540	Bur, No.559, A. Hp.	50790	Bur, No.221, St. Hp.
50650	Bur, No. 6, St. Hp.	50830	Bur, No.558, St. Hp.
50660	Bur, No. 8, St. Hp.	50850	Bur, No.560, St. Hp.
50670	Bur, No. 9, St. Hp.	51690	Cleaners, No. 3
50700	Bur, No. 34, St. Hp.	52700	Excavators, No. 57
50730	Bur, No. 39, St. Hp.	52710	Excavator, No. 58
		53180	Forceps, No. 15.

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